107TH CONGRESS *1st Session* } HOUSE OF REPRESENTATIVES { REPORT 107–

MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001

OCTOBER , 2001.—Ordered to be printed

Mr. THOMAS, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

_____ VIEWS

[To accompany H.R. 2768]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2768) to amend title XVIII of the Social Security Act to provide regulatory relief and contracting flexibility under the Medicare Program, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Regulatory and Contracting Reform Act of 2001".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(d) CONSTRUCTION.—Nothing in this Act shall be construed—

(1) to compromise or affect existing legal authority for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(e) USE OF TERM SUPPLIER IN MEDICARE.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 2. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d)(1) The Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month unless publication on another date is necessary to comply with requirements under law.

"(2) The Secretary shall coordinate issuance of new regulations relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.".

(2) REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act only be promulgated on a single day every calendar quarter.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the end of the comment period respecting such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes a notice of continuation of the regulation that includes an explanation of why the regular timeline was not complied with. If such a notice is published, the regular timeline for publication of the final regulation shall be treated as having begun again as of the date of publication of the notice.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the

applicable timeline under this paragraph and that provides an explanation for such failures.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary of Health and Human Services shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 3. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES; TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—Section 1871 (42 U.S.C. 1395hh), as amended by section 2(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the date the change was issued, unless the Secretary determines that such retroactive application would have a positive impact on beneficiaries or providers of services and suppliers or would be necessary to comply with statutory requirements.

"(B) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not become effective until at least 30 days after the Secretary issues the substantive change.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(b) RELIANCE ON GUIDANCE.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(c) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary of Health and Human Services and the Secretary's contractors authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than January 1, 2003.

SEC. 4. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (3) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function or activity in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function or activity in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(3) FUNCTIONS DESCRIBED.—The functions referred to in paragraph (1) are payment functions, provider services functions, and beneficiary services functions as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary and serving as a channel of communication from providers of services and suppliers to the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

"(4) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

"(C) TRANSFER OF FUNCTIONS.—Functions may be transferred among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers.

"(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(3). In developing such requirements, the Secretary may consult with providers of services and suppliers and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—A medicare administrative contractor shall be liable to the United States for a payment referred to in paragraph (1) or (2) if, in connection with such payment, an individual referred to in either such paragraph acted with gross negligence or intent to defraud the United States.

"(4) INDEMNIFICATION BY SECRETARY.—The Secretary shall make payment to a medicare administrative contractor under contract with the Secretary pursuant to this section, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such medicare administrative contractor, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any civil suit, action, or proceeding brought against such medicare administrative contractor or person related to the performance of any duty, function, or activity under such contract, if due care was exercised by the contractor or person in the performance of such duty, function, or activity.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary of Health and Human Services shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services,"; and

(II) by striking "carrier" and inserting "medicare administrative contractor";

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,"; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor";

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), by striking "carrier" and inserting "medicare administrative contractor";

(E) in paragraph (5), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier" and "carrier responses" and inserting "contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor" and "contractor responses", respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2003, and the Secretary of Health and Human Services is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1), consistent with the requirements under such section to competitively bid all contracts within 5 years after the effective date in paragraph (1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

SEC. 5. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (i), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2002, the Secretary of Health and Human Services shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 4(a)(1), is amended by adding at the end the following new subsection:

"(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

"(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall, in consultation with representatives of providers and suppliers, develop and implement by October 1, 2003, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

"(2) IDENTIFICATION OF BEST PRACTICES.—The Secretary shall identify the best practices developed by individual medicare administrative contractors for educating providers of services and suppliers and how to encourage the use of such best practices nationwide.".

(2) REPORT.—Not later than October 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of

the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as the basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 4(a)(1) and as amended by subsection (b), is further amended by adding at the end the following new subsection:

"(f) RESPONSE TO INQUIRIES; TOLL-FREE LINES.—

"(1) CONTRACTOR RESPONSIBILITY.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing—

"(A) respond in a clear, concise, and accurate manner to specific billing and cost reporting questions of providers of services and suppliers;

"(B) maintain a toll-free telephone number at which providers of services and suppliers may obtain information regarding billing, coding, and other appropriate information under this title;

"(C) maintain a system for identifying (and disclosing, upon request) who provides the information referred to in subparagraphs (A) and (B); and

"(D) monitor the accuracy, consistency, and timeliness of the information so provided.

"(2) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under paragraph (1)(D). The Secretary shall, in consultation with organizations representing providers of services and suppliers, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2003.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—For each of fiscal years 2003 and 2004, there are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $10,000,000 .

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 6. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary of Health and Human Services shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary of Health and Human Services shall provide that, absent

evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2003, $1,000,000, and

(2) for fiscal year 2004, $6,000,000.

SEC. 7. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; MEDICARE PROVIDER OMBUDSMAN";

(2) by inserting "PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint a Medicare Provider Ombudsman. The Ombudsman shall—

"(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

"(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.".

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"SEC. 1807. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and advocacy.

"(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

"(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

"(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

"(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

"(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

"(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.".

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2002 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: "The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

SEC. 8. PROVIDER APPEALS.

(a) MEDICARE ADMINISTRATIVE LAW JUDGES.—Section 1869 (42 U.S.C. 1395ff), as amended by section 521(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–534), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by adding at the end the following new subsection:

"(g) MEDICARE ADMINISTRATIVE LAW JUDGES.—

"(1) TRANSITION PLAN.—Not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall develop and implement a plan under which the functions of administrative law judges responsible for hearing cases under this title (and related provisions in title XI) shall be transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services. The plan shall include recommendations with respect to—

"(A) the number of administrative law judges and support staff required to hear and decide such cases in a timely manner; and

"(B) funding levels required for fiscal year 2004 and subsequent fiscal years under this subsection to hear such cases in a timely manner.

Nothing in this subsection shall be construed as affecting the independence of administrative law judges from the Department of Health and Human Services and from medicare contractors in carrying out their responsibilities for hearing and deciding cases.

"(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary to increase the number of administrative law judges described in paragraph (1) and to improve education and training for such judges and their staffs in carrying out functions under this title, $5,000,000 for fiscal year 2003 and such sums as are necessary for fiscal year 2004 and each subsequent fiscal year.

"(3) SUBMITTAL OF PLAN TO CONGRESS AND GAO; REPORT OF GAO.—Not later than July 1, 2003, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives, the Committee on Finance of the Senate, and the Comptroller General of the United States the terms of the plan developed under paragraph (1). No later than September 1, 2003, the Comptroller General shall submit to such Committees a report containing an evaluation of the terms of such plan.".

(b) PROCESS FOR EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–534), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(A) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(B) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that it does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review panel—

"(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

"(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is an administrative law judge, the Departmental Appeals Board, a qualified independent contractor (as defined in subsection (c)(2)), or an entity designated by the Secretary for purposes of making determinations under this paragraph.".

(2) APPLICATION TO TERMINATION PROCEEDINGS.—Section 1866(h) (42 U.S.C. 1395cc(h)) is amended by adding at the end the following new paragraph:

"(3) The provisions of section 1869(b)(2) shall apply with respect to determinations described in paragraph (1) in the same manner as they apply to a provider of services that has filed an appeal under section 1869(b)(1).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to appeals filed on or after October 1, 2002.

(c) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–534), as enacted into law by section 1(a)(6) of Public Law 106–554, and as amended by subsection (b), is further amended by adding at the end the following new paragraph:

"(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

SEC. 9. RECOVERY OF OVERPAYMENTS AND PREPAYMENT REVIEW; ENROLLMENT OF PROVIDERS.

(a) RECOVERY OF OVERPAYMENTS AND PREPAYMENT REVIEW.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsections:

"(f) RECOVERY OF OVERPAYMENTS AND PREPAYMENT REVIEW.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), the Secretary shall enter into a plan (which meets terms and conditions determined to be appropriate by the Secretary) with the provider of services or supplier for the offset or repayment of such overpayment over a period of not longer than 3 years, or in the case of extreme hardship (as determined by the Secretary) over a period of not longer than 5 years. Interest shall accrue on the balance through the period of repayment.

"(B) HARDSHIP.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

"(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

"(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

"(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or if there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(2) LIMITATION ON RECOUPMENT UNTIL DETERMINATION BY QUALIFIED INDEPENDENT CONTRACTOR.—

"(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in paragraph (9)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

"(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

"(3) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—

"(A) IN GENERAL.—A medicare contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

"(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

"(4) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

"(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

"(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

"(5) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(6) CONSENT SETTLEMENT REFORMS.—

"(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary analysis indicates that there would be an overpayment; and

"(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of

claims and the provider of services or supplier agrees not to appeal the claims involved.

"(7) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

"(A) LIMITATION ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a sustained or high level of payment error (as defined in paragraph (4)(A)).

"(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

"(8) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall provide for an exit conference with the provider or supplier during which the contractor shall—

"(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services or supplier of the appeal rights under this title;

"(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(9) DEFINITIONS.—For purposes of this subsection:

"(A) MEDICARE CONTRACTOR.—The term 'medicare contractor' has the meaning given such term in section 1889(g).

"(B) RANDOM PREPAYMENT REVIEW.—The term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

"(g) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).".

(b) PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(A) by adding at the end of the heading the following: "; ENROLLMENT PROCESSES"; and

(B) by adding at the end the following new subsection:

"(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(2) APPEAL PROCESS.—Such process shall provide—

"(A) a method by which providers of services and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial; and

"(B) prompt deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment) and for consideration of appeals.".

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall provide for the establishment of the enrollment and appeal process under the amendment made by paragraph (1) within 6 months after the date of the enactment of this Act.

(c) PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.—The Secretary of Health and Human Services shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 5(f)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

SEC. 10. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 11. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary of Health and Human Services may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has conducted appropriate outreach to physicians for education and training with respect to the guidelines.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be of sufficient length to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(B) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians.

(2) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians services in teaching settings and at one shall be conducted in a setting other than a teaching setting.

(3) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits.

(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the modified evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) enhance clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary of Health and Human Services shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) The Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. The Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 12. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) IMPROVED COORDINATION BETWEEN FDA AND CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

(1) IN GENERAL.—Upon request by an applicant and to the extent feasible (as determined by the Secretary of Health and Human Services), the Secretary shall, in the case of a class III medical device that is subject to premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act, coordinate reviews of coverage decisions under title XVIII of the Social Security Act with the review for application for premarket approval conducted by the Food and Drug Administration under such section. Such coordination shall include the sharing of appropriate information.

(2) PUBLICATION OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to appropriate Committees of Congress a report that contains the plan for improving such coordination and for shortening the time lag between the premarket approval by the Food and Drug Administration and coding and coverage decisions by the Centers for Medicare & Medicaid Services.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the criteria for coverage of a medical device under title XVIII of the Social Security Act nor premarket approval by the Food and Drug Administration.

(b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as "CMS").

(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under title XVIII of the Social Security Act with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under title XVIII of the Social Security Act.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers For Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2002, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(A) in subsection (a)(1)—

(i) in subparagraph (R), by striking "and" at the end;

(ii) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(iii) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)."; and

(B) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(2) EFFECTIVE DATE.—The amendments made by this paragraph (1) shall apply to hospitals as of July 1, 2002.

(e) IOM STUDY ON LOCAL COVERAGE DETERMINATIONS.—

(1) STUDY.—The Secretary shall enter into an arrangement with the Institute of Medicine of the National Academy of Sciences under which the Institute shall conduct a study on the capabilities and information available for local coverage determinations (including the application of local medical review policies) under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(A) the consistency of the definitions used in such determinations;

(B) the extent to which such determinations are based on evidence, including medical and scientific evidence;

(C) the advantages and disadvantages of local coverage decisionmaking, including the flexibility it offers for ensuring timely patient access to new medical technology for which data are still be collected;

(D) whether local coverage determinations are made, in the absence of adequate data, in order to collect such data in a manner that results in coverage of experimental items or services; and

(E) the advantages and disadvantages of maintaining local medicare contractor advisory committees that can advise on local coverage decisions based on an open, collaborative public process.

(2) REPORT.—Such arrangement shall provide that the Institute shall submit to the Secretary a report on such study by not later than 3 years after the date of the enactment of this Act. The Secretary shall promptly transmit a copy of such report to Congress.

(f) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2003 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

SEC. 13. MISCELLANEOUS PROVISIONS.

(a) TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in paragraph (2), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(2) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this paragraph are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the beneficiary and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

(b) CLARIFICATION OF PRUDENT LAYPERSON TEST FOR EMERGENCY SERVICES UNDER THE MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) In the case of hospital services and physicians' services that—

"(1) are furnished, to an individual who is not enrolled in a Medicare+Choice plan under part C, by a hospital or a critical access hospital; and

"(2) are needed to evaluate or stabilize an emergency medical condition (as defined in section 1852(d)(3)(B), relating to application of a prudent layperson rule) and that are provided to meet the requirements of section 1867,

such services shall be deemed to be reasonable and necessary for the diagnosis or treatment of illness or injury for purposes of subsection (a)(1)(A).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2002.

(c) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—The Secretary of Health and Human Services shall submit to Congress as expeditiously as practicable the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(d) AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.—

(1) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following new subparagraph:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I).

The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.".

(2) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to hospice care provided on or after the date of the enactment of this Act.